VIRGINIA MEDICAID REQUEST FOR SERVICE AUTHORIZATION CIALIS®

COMMONWEALTH of VIRGINIA
Department of Medical Assistance Services

Requests for service authorization (SA) must include patient name, Medicaid ID#, drug name, and appropriate clinical information to support the request on the basis of medical necessity. Please include all requested information; incomplete forms will delay the SA process. **Submission of documentation does not guarantee coverage by the Department of Medical Assistance Services and final coverage decisions may be affected by the specific Medicaid Limitations.**

The completed form may be **FAXED TO 800-932-6651**. Requests may be phoned to 800-932-6648.
Requests may be mailed to: Magellan Medicaid Administration / 11013 W. Broad St / Glen Allen, VA 23060 / ATTN: MAP

Today's Date: ___ ___/___ ___/___ ___ ___ ___ Requested Start Date: ___ ___/___ ___/___ ___ ___ ___

PATIENT INFORMATION

Name: (Last, First) _____ **Medicaid ID#:** ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ __

Date of Birth: ___ ___/___ ___/___ ___ ___ ___ **Gender:** □ **Male** □**Female**

DRUG INFORMATION

Drug Name/ Form: _____ **Strength:** _____

Dosing Frequency: _____ **Length of Therapy:** _____

DIAGNOSIS AND MEDICAL INFORMATION – Please Answer All Questions To facilitate processing

Does the patient have a diagnosis of Benign Prostatic Hyperplasia? ☐ **Yes** ☐ **No**

If no, please provide diagnosis. Diagnosis: _____

Has patient tried and failed (or have contraindications to) Alpha Blockers and Androgen Hormone Inhibitors? ☐**Yes** ☐**No**
If yes, pleases list agents attempted and outcome or contraindications.

1)

2)

Has patient had a consult or been evaluated by Urologist? ☐ **Yes** ☐ **No**

Medical necessity: Provide clinical evidence that the preferred agent(s) will not provide adequate benefit:

Does the physician attest that the patient is NOT on the state list of sex offenders? ☐ **Yes** ☐ **No**

Virginia sex offender website: http://sex-offender.vsp.virginia.gov/sor/

PRESCRIBER INFORMATION

Name (print):_____ NPI Number: _____

Phone Number: (___ ___ ___) ___ ___ ___-___ ___ ___ ___ Fax Number: (___ ___ ___) ___ ___ ___-___ ___ ___ ___

Signature of Prescribing Provider: _____

PLEASE INCLUDE ALL REQUESTED INFORMATION
INCOMPLETE FORMS WILL DELAY THE SERVICE AUTHORIZATION PROCESS

FAX TO 800-932-6651
SERVICE AUTHORIZATION CRITERIA IS SUBJECT TO CHANGE.
http://www.virginiamedicaidpharmacyservices.com